Provider Participation Requirements (LEA)

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Provider Participation Requirements (LEA)

MANAGED CARE AND FEE FOR SERVICE DELIVERY SYSTEMS

Most of the services covered through Virginia's Medicaid and FAMIS programs are furnished through DMAS' contracted MCOs and their network of providers; however, there are exceptions. Covered services provided by Local Education Agency (LEA) providers to member students when authorized by the student's Individualized Education Plan (IEP) are managed by DMAS Fee-for-Service (FFS) system, and those providers must follow DMAS FFS policies and procedures as set out in the LEA Provider Manual.

LEA PARTICIPATING PROVIDER

For purposes of this manual, a "local education agency" (LEA) refers to a school division that operates local public primary and secondary schools in Virginia, as well as the Virginia School for the Deaf and Blind (VSDB). A participating LEA provider (also referred to as "LEA billing provider" or "billing provider") is a local education agency that has a current, signed Business Associate Agreement on file with the Department of Medical Assistance Services (DMAS) and is enrolled with DMAS as a participating provider.

LEA providers must complete the Business Associate Agreement as required in 45 CFR § 160.103 of the Final HIPAA Privacy Rule. More information about the Business Associate Agreement may be found on the web at www.dmas.virginia.gov.

LEA PROVIDER ENROLLMENT

For purposes of the LEA Provider Manual, DMAS distinguishes the following terms used to describe those responsible for providing LEA services:

LEA provider	The LEA or school division. Also known as the billing provider or facility provider.	An LEA provider must enroll with DMAS in order to bill for services.

Ordering, referring or prescribing (ORP) provider	The ORP provider is a qualified provider that is allowed to refer for school-based services according to their licensed scope of practice and according to state law.	An ORP provider must enroll with DMAS and may or may not render direct services.
Qualified provider	A healthcare professional licensed in Virginia and acting within their licensed scope of practice according to state law.	Qualified providers that order or refer students for services must enroll with DMAS in order to also serve as an ORP provider for school-based services.
Service rendering provider	The LEA employed or contracted staff member rendering direct services to the student.	This includes qualified providers that render direct services. It also includes unlicensed staff rendering care under the supervision of a qualified provider.

LEA providers must be currently enrolled with DMAS in order to submit claims for services provided to Medicaid or FAMIS-enrolled members. Provider-related enrollment forms, including the Participation Agreement, can be found on the Virginia Medicaid Web Portal www.virginiamedicaid.dmas.virginia.gov.

LEA providers may submit claims to DMAS for medically necessary health care services approved for Medicaid and FAMIS members receiving special education and related services pursuant to an Individualized Education Program (IEP) through the LEA. (See Chapter IV of this manual for more information on covered services.)

LEA providers may also submit claims associated with providing the federally-required screening services that are part of the early and periodic screening, diagnostic and treatment services (EPSDT) benefit for Medicaid-enrolled students. See the EPSDT Supplemental Provider Manual available online at the Virginia Medicaid Web Portal for guidance on DMAS-covered well child visits and EPSDT screenings.

NATIONAL PROVIDER IDENTIFIER (NPI) AND LEA/ORP PROVIDER ENROLLMENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique identifier for health care providers. LEA providers, and qualified providers that order, refer or prescribe (ORP) DMAS-covered services for Medicaid and FAMIS members must obtain a National Provider Identifier (NPI) and submit the NPI to DMAS at the time of enrollment.

NPIs may be disclosed to other entities that need the health care providers' NPIs in order to carry out HIPAA standard transactions, as defined in 45 CFR Part 16, HIPAA Administrative Simplification: Standard Unique Health Identifier for Health Care Providers; Final Rule (NPI Final Rule).

This manual contains information about provider qualifications and specific details concerning the DMAS reimbursable services for LEAs. LEA providers, and their associated ORP and service rendering providers must comply with all sections of this manual and must practice in accordance with the requirements of the appropriate licensing board within the Department of Health Professions (as applicable) to maintain continuous participation in the DMAS Program.

PROVIDER REQUESTS FOR ENROLLMENT

DMAS strongly encourages LEA and ORP providers to register with the Virginia Medicaid Web Portal located at www.virginiamedicaid.dmas.virginia.gov. Registration with the portal is required in order to access and use the online enrollment and revalidation system. If a provider is unable to enroll electronically through the web portal, they can download a paper enrollment form from the Virginia Medicaid web-based portal and follow the instructions on the form for submission. It must be emphasized, however, that the provider must register with the Virginia Medicaid Web Portal in order to complete the provider revalidation process. (See Revalidation Requirements below.)

If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio

response system provides similar information and can be accessed 24 hours per day, seven days per week by calling 1-800-884-9730 or 1-800-772-9996.

For questions regarding the online or paper enrollment process, please contact Provider Enrollment Services toll free at: 1-888-829-5373 or local 1-804-270-5105.

PROVIDER SCREENING REQUIREMENTS (LEA)

LEA billing and ORP providers must undergo a federally mandated comprehensive screening as part of the DMAS enrollment process. (See Limited Risk Screening Requirements below.). This comprehensive screening is repeated every five years as a part of the DMAS provider revalidation process. (See section below on Revalidation Requirements.) A partial screening process is also performed on a monthly basis for all currently enrolled providers.

Limited-Risk Screening Requirements

The following screening requirements will apply to limited-risk provider class types: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type prior to making an enrollment determination; (2) verification that a provider or supplier meets applicable licensure requirements; and (3) federal and state database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs. LEA providers and their associated ORP providers fall into this category.

Moderate-Risk Screening Requirements

The following screening requirements will apply to moderate-risk provider class types: Unannounced pre- and/or post-enrollment site visits in addition to those screening requirements applicable to the limited-risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High-Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate-risk provider class types categories listed above, providers in the high-risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the “high” level of screening.

Application Fees

If a provider class type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal provider enrollment paper applications, online enrollment tool, and incorporated into the revalidation process.

The Centers for Medicare and Medicaid Services (CMS) determine what the application fee is each year. This fee is not required to be paid to Virginia Medicaid if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

LEA providers, and ORP providers enrolling for purposes of LEA-based services, are not charged an enrollment fee.

Out-of-State Provider Enrollment Requests

Providers that are located outside of the Virginia border and require a site visit as part of the Affordable Care Act are required to have their screening to include the passing of a site visit previously completed by CMS or their State's Medicaid program prior to enrollment in Virginia Medicaid. If the application is received prior to the completion of the site visit as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E) by the entities previously mentioned above, then the application will be rejected. (This does not apply to LEA providers or their employees or contractors.)

REVALIDATION REQUIREMENTS (LEA)

Qualified providers licensed through the Virginia Department of Health Professions (DHP) must follow DHP policies and procedures and maintain a valid, up-to-date license. DMAS system information is linked to the DHP system, so that no additional action on the part of the provider is required. Exception: Providers holding licenses that are administered by an entity other than DHP must update their licenses directly with DMAS.

All enrolled qualified providers in the Virginia Medicaid program will be notified in writing of a revalidation due date, and informed of new or revised provider screening requirements in the revalidation notice. Providers must complete the revalidation process using the DMAS web portal. If a provider is currently enrolled as a Medicare provider, DMAS may rely on the enrollment and screening facilitated by CMS to satisfy our provider screening requirements.

ORDERING, REFERRING AND PRESCRIBING (ORP) PROVIDERS (LEA)

The Code of Federal Regulations 455:410(b) requires ORP providers to enroll to meet ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid enrollees originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid.

LEA AND ORP PROVIDER PARTICIPATION REQUIREMENTS

Providers enrolled with DMAS must perform the following activities as well as any other specified by DMAS:

- Immediately notify the Provider Enrollment Unit, in writing, of any change in the information which the provider previously submitted to the Provider Enrollment Unit.
- Avoid actions that would restrict a member from seeking covered services from any institution, pharmacy, or practitioner that is enrolled with DMAS and qualified to perform necessary covered services.
- Ensure the recipient's freedom to reject medical care and treatment.
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin.
- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities.
- Provide recipients the same quality of service and in the same mode of delivery as provided to the general public.
- Accept DMAS payment from the first day of eligibility if the provider was aware that application for Medicaid or FAMIS eligibility was pending at the time that services began.
- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable charge. 42 CFR §447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the state. The provider may not seek to collect from a

Medicaid/FAMIS recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established DMAS allowance for the service rendered. The provider may not charge DMAS or the recipient for broken or missed appointments.
- Accept assignment of Medicare benefits for eligible Medicaid recipients.
- Use Program-designated billing forms for submission of charges.
- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. Refer to Chapter VI of this manual for specific record retention policy.
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.
- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance.
- Hold confidential, and use for authorized DMAS purposes only, all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

PROVIDER RESPONSIBILITIES TO IDENTIFY EXCLUDED INDIVIDUALS AND ENTITIES (LEA)

DMAS payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the DMAS payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded individual or entity for the provision of items or services reimbursable by DMAS may be subject to overpayment liability as well as civil monetary penalties. All LEA providers are required to immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS

Attn: Program Integrity/Exclusions

600 E. Broad St, Suite 1300

Richmond, VA 23219

-or-

E-mailed to: providerexclusions@dmas.virginia.gov

SPECIAL PARTICIPATION REQUIREMENTS

The following paragraphs outline the special participation conditions for LEA billing providers and their associated qualified providers performing covered services. Qualified providers must meet all qualifications and requirements for their specialty as defined in State law, and they must be employed by or contracted by the billing LEA.

DMAS covers the following school-based services: (Service conditions are covered in Chapter IV of this manual.)

- Well child visits and EPSDT screenings (see the EPSDT Supplemental Provider Manual),
- Physical therapy,
- Occupational therapy,
- Speech-language therapy,
- Audiology,
- Nursing,
- Psychiatry, psychology and mental health,
- Personal care,
- Medical evaluations,
- Specialized Transportation, and
- Evaluations for DMAS billable special education and related services.

LEAs must:

- Utilize DMAS-qualified providers to provide DMAS-billable services as required by state law and regulations;
- Include an NPI of a DMAS-enrolled ORP provider on school-based service claims, with the exception of personal care and specialized transportation services, and medical evaluation services performed by a physician, nurse practitioner or physician's assistant.

The following DMAS-qualified providers of LEA school-based services must enroll with DMAS as ORP providers in order to refer for billed services within the program:

Audiologists	Physicians including Psychiatrists

Clinical Psychologists	Professional Counselors
Clinical Social Workers	Psychiatric Clinical Nurse Specialists
Marriage and Family Therapists	School Psychologists
Nurse Practitioners	School Psychologists (Limited)
Occupational Therapists	School Social Workers
Physical Therapists	Speech-Language Pathologists (master's level only)

The following providers may not act as ORP providers of LEA school-based services, and are not required to obtain an NPI number or enroll with DMAS:

- Registered nurses, licensed practical nurses
- Personal care assistants
- School specialized transportation providers
- Occupational therapy assistants
- Physical therapy assistants
- Bachelors level speech-language pathologists
- Psychological testing technicians

DMAS does not reimburse services provided by a parent, stepparent or legal guardian of the student. Payment may be made for services rendered by other family members. In those circumstances, the family member providing therapy or other service to the student must be employed by or under contract with the LEA and must meet all DMAS-required provider qualifications.

PROVIDER QUALIFICATIONS FOR SPECIFIC SERVICES

Requirements for Providing Clinical Supervision According to Board Licensing Requirements

In addition to the requirements listed in the LEA Provider Manual, DMAS-qualified providers providing clinical supervision to professionals according to Virginia licensing board requirements must follow their individual licensing-related laws and regulations regarding supervision requirements as detailed in the Code of Virginia and Virginia Administrative Code, as applicable. This includes requirements for direct (face-to-face)

supervision versus indirect (telephonic or off-site) supervision, and the frequency of supervisory visits.

If the individual licensing or special education requirements do not include specific time periods regarding supervisory visits (e.g., every 30 days) or type of supervisory visits (e.g., in-person), then the qualified supervising provider shall complete supervisory visits with the supervisee at least every 90 days, to ensure both the quality and appropriateness of the services provided, and to make any needed adjustments to the treatment plan. Supervision may be provided indirectly (e.g., telephonically), if allowed under the individual licensing requirements. The supervisor must document supervisory activities as described in Chapter VI of this manual.

Supervision of Personal Care Assistants

Any licensed practitioner who meets DMAS qualified provider requirements stated in this chapter may supervise the personal care assistant (PCA) providing services within the scope of the licensed practitioner's individual discipline. In cases where a single PCA is providing personal care services to a student based on multiple service-specific plans of care, the PCA's work must be supervised by a qualified providers from each of the services involved.

Examples of PCA services and suggestions for the appropriate supervising licensed practitioner of the healing arts include:

- Assistance to increase adaptive behavioral functioning supervised by the licensed provider of psychiatry, psychological or mental health services;
- Assistance with activities of daily living supervised by the physical therapist (PT), occupational therapist (OT), speech and language pathologist (SLP) or RN;
- Assistance with hearing aids and assistive listening devices supervised by the audiologist or SLP;
- Assistance with adaptive equipment supervised by OT, PT, or SLP;
- Assistance with ambulation and exercise supervised by the PT or OT;
- Assistance with remedial services to reduce the impact of the disability, supervised by a DMAS approved provider as documented in this chapter; and
- Monitoring a health related service supervised by a RN.

Physical Therapy Services

Physical therapy services must be performed by the following:

- A physical therapist (PT) licensed by the Virginia Board of Physical Therapy; or
- A physical therapy assistant (PTA) licensed by the Virginia Board of Physical Therapy under the supervision of a PT.

Occupational Therapy Services

Occupational therapy services must be performed by the following:

- An occupational therapist (OT) licensed by the Virginia Board of Medicine; or
- An occupational therapy assistant (OTA) licensed by the Virginia Board of Medicine under the supervision of a licensed occupational therapist.

Speech-Language Therapy Services

Speech-language therapy services must be performed by:

- A speech-language pathologist (SLP) licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech-Language Pathology with a Master's Degree*; or
- A SLP licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech-Language Pathology with licensure as school speech-language pathologist without a Master's degree, under the supervision of a licensed SLP with a Master's Degree.

*A master's level SLP with a Virginia Board of Audiology and Speech Language Pathology provisional license is considered a qualified provider of LEA services and does not require supervision.

Audiology Services

Audiology services must be provided by an audiologist licensed by the Virginia Board of Audiology and Speech-Language Pathology.

Nursing Services

Nursing services must be provided by a:

- Licensed Registered Nurse (RN); or
- Licensed Practical Nurse (LPN) under the supervision of a RN as required by the Virginia Board of Nursing.

Psychiatry, Psychology, and Mental Health Services

Psychiatry, psychology and mental health services may be provided by:

- A psychiatrist licensed by the Board of Medicine;
- A licensed clinical psychologist, licensed school psychologist, or licensed school psychologist-limited licensed by the Board of Psychology;
- A licensed clinical social worker (LCSW) licensed by the Board of Social Work;
- A licensed professional counselor (LPC) licensed by the Board of Counseling;
- A psychiatric clinical nurse specialist (CNS) licensed by the Board of Nursing and certified by the American Nurses Credentialing Center;
- A licensed marriage and family therapist (LMFP) licensed by the Board of Counseling; or
- A school social worker endorsed by Department of Education.

Psychological Testing Technicians

A DMAS qualified provider acting within the scope of his or her licensure may utilize a psychological testing technician* to administer psychological tests as a component of the psychological testing evaluation service. The qualified provider must provide general supervision which, in this context, means under the qualified provider's overall direction and control, but his or her presence is not required during the performance of the procedure.

*It is acceptable for a psychology intern to perform the role of psychological testing technician. These services may be billed as long as the testing technician/psychology intern is a LEA-paid position.

Personal Care Assistant Services

Basic qualifications for PCAs include:

- Physical ability to do the work;
- Ability to be trained by appropriate licensed professional to perform tasks;
- Perform services consistent with the training received by the appropriate DMAS

qualified provider.

Training and supervision of PCAs must be provided by the appropriate, discipline-specific DMAS qualified provider of the services as listed in the plan of care.

Medical Evaluation Services

Qualified providers of medical evaluation services include:

- A physician licensed by the Board of Medicine;
- A physician assistant licensed by the Board of Medicine; or
- A nurse practitioner licensed by the Board of Nursing.

Well Child Visits and EPSDT Screening Services

Well child visits and EPSDT screening services must be conducted by:

- A physician licensed by the Board of Medicine;
- A physician assistant licensed by the Board of Medicine; or
- A nurse practitioner licensed by the Board of.

See the EPSDT Supplemental Provider Manual available online at the Virginia Medicaid Web Portal for guidance on DMAS-covered well child visits and EPSDT screenings.

Specialized Transportation

Providers of specialized transportation services must be employed through the LEA or have a contract with the LEA, and must meet applicable federal and state statutes and regulations for transporting students. The specialized transportation vehicle must be a specially adapted school vehicle utilized to transport a Medicaid or FAMIS-enrolled student from (to) their home or other "originating site" to (from) the site where they are receiving a DMAS billable and paid service that is documented in the student's IEP.

Note: Specialized transportation service is not covered by the VA Medicaid Non-Emergency Transportation (NET) Brokerage program. Specialized transportation arrangements and services are provided only by the LEA.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended, (29 U.S.C. § 794) provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. Each Medicaid participating provider is responsible for making provisions for such disabled individuals in the provider's programs and activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. The provider's signature on the claim indicates their attestation of compliance with the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office of Civil Rights (OCR) any evidence regarding non-compliance with these requirements.

TERMINATION OF PROVIDER PARTICIPATION (LEA)

The participation agreement will be time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to its expiration.

A participating provider may terminate participation with DMAS at any time; however, written notification of voluntary termination must be made to the Provider Enrollment Unit thirty (30) calendar days prior to the effective date.

DMAS may terminate a provider from participation upon thirty (30) calendar days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to recipients subsequent to the date specified in the termination notice.

Subsection 32.1-325 D.2 of the *Code of Virginia* mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 calendar days, notify the Department of this conviction and relinquish the agreement. Reinstatement will be contingent upon the provisions of State law.

Appeals of Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to Virginia Code §32.1-325D and E. The provider may appeal the decision in accordance with the Administrative Process Act (Virginia Code §2.2-4000 et seq.). Such a request must be in writing and must be filed with the DMAS Appeals Division **within 15 calendar days** of the receipt of the notice of termination or denial.

Appeals of Adverse Actions

Definitions:

Administrative Dismissal – means:

1) A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings; or

2) The dismissal of a member appeal on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the MCO or other DMAS Contractor.

Adverse Action – means the termination, suspension, or reduction in covered benefits or the denial, in whole or in part, of payment for a service.

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) The denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) The failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals; (vi) For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) is not an adverse benefit determination.

Appeal – means:

1) A member appeal is:

    a. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined

as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

b. For members receiving FFS services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. If an internal appeal is required by the DMAS Contractor, an appeal to DMAS may only be requested after the Contractor's internal appeal process is exhausted. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

2) For services that have already been rendered, a provider appeal is:

a. A request made by an MCO's provider (in-network or out-of-network) to review the MCO's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the MCO's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.; or

b. For FFS services, a request made by a provider to review DMAS' adverse action or the DMAS Contractor's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. If an adverse action requires reconsideration before appealing to DMAS, the provider must exhaust the Contractor's reconsideration process, after which Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.

Internal Appeal – means a request to the MCO or other DMAS Contractor by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination or DMAS Contractor's adverse action. The internal appeal is the only level of appeal with the MCO or other DMAS Contractor and must be exhausted by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before the member may initiate a State fair hearing.

Reconsideration – means a provider's request for review of an adverse action. The MCO's or DMAS Contractor's reconsideration decision is a pre-requisite to a provider filing an appeal to the DMAS Appeals Division.

State Fair Hearing – means the Department's *de novo* evidentiary hearing process for member appeals. Any internal appeal decision rendered by the MCO or DMAS Contractor may be appealed by

the member to the Department's Appeals Division. The Department conducts *de novo* evidentiary hearings in accordance with regulations at 42 C.F.R. § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

Transmit – means to send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission.

MEMBER APPEALS

Information for providers seeking to represent a member in the member's appeal of an adverse benefit determination is located in Chapter III.

PROVIDER APPEALS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when an adverse action is taken that affords appeal rights to providers.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted if the action involves a DMAS claim under the EAPG payment methodology or involves a ClaimCheck denial. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the underpayment, overpayment, and/or denial to the attention of the Program Operations Division at the following address:

Program Operations Division

Department of Medical Assistance Services

600 East Broad Street,

Richmond, Virginia 23219

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, in whole or part, as a result of the reconsideration process, the provider may then appeal that decision to the DMAS Appeals Division, as set forth below.

Internal appeal rights with a managed care organization ("MCO") must also be exhausted prior to appealing to DMAS if the individual is enrolled with DMAS through a Virginia Medicaid MCO.

For services that have been rendered and applicable reconsideration or MCO internal appeal rights have been exhausted, providers have the right to appeal adverse actions to DMAS.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in the Code of Virginia § 2.2-4000 *et. seq.* and the Virginia Administrative Code 12 VAC 30-20-500 *et. seq.*

Provider appeals to DMAS must be submitted in writing and **within 30 calendar days** of the provider's receipt of the DMAS adverse action or final reconsideration/MCO internal appeal decision. However, provider appeals of a termination of the DMAS provider agreement that was based on the provider's conviction of a felony must be appealed **within 15 calendar days** of the provider's receipt of the DMAS adverse action. The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues from the action being appealed. Failure to file a written notice of informal appeal within the prescribed timeframe will result in an administrative dismissal of the appeal.

The appeal must be filed with the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System ("AIMS") at https://www.dmas.virginia.gov/appeals/. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.

- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:

    - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;

    - Email to appeals@dmas.virginia.gov; or

    - Fax to (804) 452-5454.

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. will be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date will be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision will result in dismissal of the appeal. The notice of appeal must be transmitted through the same methods listed above for informal appeals.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the APA at the Code of Virginia § 2.2-4025, *et. seq*. and the Rules of Court.

The provider may not bill the member for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

DMAS PROGRAM INFORMATION

Federal regulations governing program operations require Virginia DMAS to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information.

A provider may not wish to receive a provider manual and DMAS memoranda because he or she has access to the publications as part of a group practice. To suppress the receipt of this information, the Provider Enrollment Unit requires the provider to complete the Mail Suppression Form and return it to:

Virginia Medicaid Provider Enrollment Services

P.O. Box 26803

Richmond, VA 23261-6803

Phone (804) 270-5105 or 1-888-829-5373 (In-state Toll Free)

Fax (804) 270-7027 or 1-888-335-8476

Upon receipt of the completed form, PEU will process it and the provider named on the form will no longer receive publications from DMAS. To resume the mailings, a written request sent to the same address is required.